Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pine Creek Medical Center

Respondent Name
American Home Assurance Co

MFDR Tracking Number
M4-14-3639-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 12, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "LABS are not paid under the OPPS, they are payable under the 2014 Clinical Diagnostic Laboratory Medicare's methodology (part B) Fee Schedule. CMS.GOV has all the information."

Amount in Dispute: $99.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Carrier is going to maintain their denial that the additional $99.98 is not owed to the requestor, Pine Creek Medical."

Response Submitted by: AIG Insurance, 4100 Alpha Road, Suite 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2014	Laboratory Services	$99.98	$48.39

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 96 – Non-covered charge(s).

Issues

1. Did the requestor support services are payable?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203(c), "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." Review of the corrected claim finds;
    - Original claim contained "Type of bill" 131
    - Pine Creek Medical Ctr Lab **LIVE** states, "Reason for Visit: Preop/Back Surgery"
    - Claim with Type of bill 141 states, "Requesting 200% of OPPS"

   From all of the above it would appear that these lab charges are related to surgery services. However, the carrier provided no evidence to support a surgery was made for the same diagnosis, done by the same physician. Therefore, separate payment will be allowed. The maximum allowable reimbursement will be calculated as follows;

Date of Service	Submitted Code	Units	Billed amount	MAR (Fee Schedule x 125%)
March 18, 2014	36415	1	$25.00	3.00 x 125% = $3.75
March 18, 2014	80048	1	$119.50	11.54 x 125% = $14.43
March 18, 2014	85025	1	$106.50	10.61 x 125% = $13.26
March 18, 2014	85610	1	$88.50	5.37 x 125% = $6.71
March 18, 2014	85730	1	$88.50	8.19 x 125% = $10.24
			$428.00	$48.39

2. The total allowable for the services in dispute is $48.39. The amount paid by the carrier is $0.00. The remaining balance is $48.39. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $48.39.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $48.39 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 13, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.